



Suffolk County
Department of Health Services
MEDICAL RESERVE CORPS

225 Rabro Drive East, Hauppauge, New York 11788
Telephone: 631-853-3055 Fax: 631-853-3073
Email: SuffolkCountyMRC@suffolkcountyny.gov



Medical Reserve Corps
Volunteer Application

I. Personal Contact Information

Last Name _____ First Name _____ MI _____
Date of Birth _____ Social Security # _____ Drivers License # _____
Home Address: Street _____ Apt. # _____
Town _____ State _____ Zip Code _____
Home Phone # () _____ Cell Phone # () _____
E-mail Address _____
Personal Beeper # () _____ Home Fax # () _____
Preferred method of contact for routine matters: _____
Preferred method of contact for emergency events: _____

II. Education, Training and Certification

Professional School Training

Institution Name _____
Contact Name _____
Mailing Address _____
Degree _____ Years Attended _____ Year Graduated _____

Postgraduate Training (residency, fellowship, practicum) (list in chronological order)

Institution Name _____

Contact Name _____

Mailing Address _____

Dates Attended _____ Program _____ Was program accredited? ☐ yes no ☐

Board Certification _____ Date _____

III. Licenses

Are you licensed in New York State in any health field? *If "Yes":*

Type of License: _____ *NYS License No.* _____ *Expiration Date:* _____

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Discipline/Specialty

Are you certified in New York State in any Health Field? If Yes:

Type of Certification _____ Certification Number _____

Expiration date: _____

Are you committed to any other agency in the event of a disaster? **Yes** _____ **No** _____

If **Yes**, to whom? _____

Would you be willing to assume a leadership role in the MRC? _____

IV. Previous Employment History

Occupation _____ Specialty _____
(Check) Full Time _____ Part Time _____ Retired _____ Student _____

Employer _____

Contact Name: _____ Contact Phone: _____

Address _____

Dates of Employment: _____ to _____

Occupation _____ Specialty _____
(Check) Full Time _____ Part Time _____ Retired _____ Student _____

Employer _____

Contact Name: _____ Contact Phone: _____

Address _____

Dates of Employment: _____ to _____

Occupation _____ Specialty _____
(Check) Full Time _____ Part Time _____ Retired _____ Student _____

Employer _____

Contact Name: _____ Contact Phone: _____

Address _____

Dates of Employment: _____ to _____

V. Certification & Training

A. Certification

	Expiration Date	Certifying Agency
1. CPR _____	_____	_____
1. HazMat _____	_____	_____
1. Bloodborne Pathogens _____	_____	_____
1. Other _____	_____	_____

B. Training

1. Are you familiar with Incident Command System of Emergency Management?

Yes _____

No _____

If yes, indicate level of understanding (a) _____ not at all (b) _____ somewhat (c) _____ fully trained

2. Have you had any training about terrorism preparedness or emergency response to terrorism (i.e. chemical, biological, radiological, etc.)

Yes _____

No _____

If Yes, please specify type of training _____

VI. References

Name _____ Address _____

Name _____ Address _____

VII. Skills Assessment

As an MRC volunteer, you will be asked to perform activities that best match your skills, interest and training. The following questions will assist in identifying training needs, interest and clinical assignments. Please describe your abilities and interests in the following areas:

Administrative Skills

Clinical Skills

Do you have any other skills/hobbies outside of your profession?

If so, what? _____

Language Skills

What languages do you *spea*k or understand, other than English? Please list and indicate level of fluency:

Languages spoken: _____ Level of fluency (*circle one*) _____ read and write

_____ **Excellent Fair Limited** **Yes No**

_____ **Excellent Fair Limited** **Yes No**

VIII. Physical Assessment

Are you able to be trained to wear PPE? **Yes** _____ **No** _____

Your overall physical health is: **Excellent** _____ **Good** _____ **Fair** _____ **Poor** _____

Please provide signed documentation of recent physical examination (within one year).

Provide documentation of Rubella, Rubeola immunity, Hep B and Titters and annual Mantoux Testing/or chest radiograph results taken after a positive PPD.

STATEMENT BY APPLICANT

All of the information that I have supplied is correct to the best of my knowledge. I do hereby give the Suffolk County Department of Health Services (SCDHS) or their designee permission to inquire into my educational background, references, driving record, present and previous employment, licenses, certifications and police record. I further give permission to the holder of any such records to release the same to the SCDHS or their designee. I hold the SCDHS or their designee harmless of any liability, whether civil or criminal, which may arise as a result of the release of the information about me. I also hold harmless any individual agency, business or corporation that provides information to the SCDHS or their designee.

I understand that I am a volunteer and will not be paid for any of my services.

I give permission for the SCDHS to release personal information to local, state and federal emergency management agencies and other Health and Human Service agencies as needed.

Please return application along with a copy of your professional license, current DEA, driver's license and your most recent curriculum vitae documenting previous work experiences.

Signed: _____ **Date:** _____

Print Name: _____

Send to:

Suffolk County Department of Health Services

Attn: MRC

225 Rabro Drive East

Hauppauge, New York 11788

Fax: (631) 853-3073